

PRINTED: 02/11/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPL IDENTIFICATION N		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
, MAD I DAY OF	· Other transfer or the contract of the contra						
		155668	B. WIN			02/07	7/2011
	ROVIDER OR SUPPLIER ENCE RETIREMENT	номе		491	ET ADDRESS, CITY, STATE, ZIP CODE 15 CHARLESTOWN ROAD EW ALBANY, IN 47150		į
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	INITIAL COMMEN This visit was for a Licensure Survey.	Recertification and State nuary 31, February 1, 2, 3, 7, 001144 155668 200256980 , TC	F	000	This plan of correction cons Mercy Providence Retireme Home's credible allegation compliance for all cited deficiencies. Nothing in thi of correction should be cons as admission by the facility violations of state and feder statutes, regulations or stan of care. This plan of correct to demonstrate compliance state and federal requireme cited during an annual surv	s plan strued of any ral dards ction is of the nts ey.	
	Residential samp	es also reflect state findings in		•	LONG TERM CARE D INDIANA STATE DEPARTMEN	IVISION	
SS=E	3 483.15(h)(2) HOU MAINTENANCE The facility must	SERVICES provide housekeeping and	; ;	= 253			: : :
LAHORATO	RY DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SI	IGNATUR	E	Executive price to a	J-,	(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		155668	B. WING		02/0	7/2011	
	PROVIDER OR SUPPLIER	номе	STREET ADDRESS, CITY, STATE, ZIP CODE 4915 CHARLESTOWN ROAD NEW ALBANY, IN 47150				
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F 253	This REQUIREME by: Based on observarinterview, the faciliand fixtures were denvironmental obsidays. The deficier rooms on the 300, 2 of 12 rooms on the 600 hall, 2 of 2 rooms on the 600 hall and 11 rein the South dining Findings include: On 01/31/11 at 1:2 Director of Dietary 1. In the South din 13 of 13 chairs we rolled up when sw On 02/03/11 betw 1:06 p.m., accomplication of the complex of	ces necessary to maintain a and comfortable interior. NT is not met as evidenced ton, record review and ty failed to ensure furniture, clean and in good repair during ervations on 2 of 5 survey at practice affected 3 of 14 hall; 2 of 14 rooms on 200 hall; the 400 hall, 2 of 9 rooms on the 700 hall; 3 of 13 hall; and 4 of 13 rooms on the sidents who utilize facility chairs a proom. A3 p.m., in the presence of the chair the following was observed: ning room the wood frames of the ere soiled with heavy dust that inped with the fingers. The entry of 12:46 p.m. and compared to the provided to the following was observed: the bod frame was soiled with the erved.	F 253	1)What corrective action/be accomplished for those residents found to have be affected by the deficient practice? The chairs in the South diminoom have been cleaned and removed. The bed frame is Room 212 been cleaned and dust removed. The wood frames of the chaoutside of room 212 have be cleaned and dust removed. The bed frames in Room 30804 (bed 1 and bed 2), 808, 703, 910 (bed 1 and bed 2) heen cleaned and dust removed. The bed frames and overbeen in room 402, 607, 608, 809, 913 have been cleaned and removed. The bed frame and wood classes in Room 308 and 310 been cleaned and dust removed.	ing d dust 2 has oved. airs een 05, 403 , 709 , 909 ave oved. d lights and dust		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF D	ROVIDER OR SUPPLIER	1 133003		I		02/0	7/2011
	ENCE RETIREMENT I	IOME		45	EET ADDRESS, CITY, STATE, ZIP CODE 015 CHARLESTOWN ROAD EW ALBANY, IN 47150		
B441 NB	ATS VGARREIS	TEMENT OF DEFICIENCIES	10			TION	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 253	Continued From pa	ge 2	F	253	2)How other residents having	ıg	:
	5, Room 308-The l	bed frame and wood chair		•	the potential to be affected b	у	
	frame was soiled w	ith dust.		ĺ	the same deficient practice	vill	•
		!		. !	be identified and what		•
	6. Room 310-The l frame was soiled w	bed frame and wood chair ith dust.			corrective action/s will be ta	ken.	:
				:	Housekeeping Director/Desig	nee	r
		frame of one bed and one over		!	will complete an audit of all		;
	the bed light was so	ollea with aust. j		i	facility bed frames, dining ro	om	1
	8 Room 403-The	bed frames were soiled with		1	chairs, resident room chairs a	nd	
	heavy dust.	bed harres were solled with		j	overbed lights to assure no ot	her	:
	,	· ·			' areas are affected with heavy	dust.	
	9. Room 607-The	frame of one bed and one over		:			1
	the bed light was so	oiled with heavy dust.			3)What measure will be put	into	!
	(A D 000 TI			!	place or what systemic char		!
		frame of one bed and one			will be made to ensure that	the	ı
	over the bed light w	as soiled with heavy dust.			deficient practice does not		!
	12 Room 804-The	frames of both beds were		,	recur?		! İ
	soiled with heavy d			i	· .		
				i	Housekeeping staff will be in		1
	12. Room 808-Th	e frame of one bed was soiled			serviced on cleaning over-be		
	with heavy dust.				lights on a daily basis, dining		
					rooms are to be dusted twice		
	1	frames of two beds and one		:	month, chairs in resident room		
	rover the bea light W	as solled with heavy dust.			are to be dusted twice a mont		
	14 Room 709_One	: e bed frame was soiled with a l		į	and bed frames are to dusted	twice	
	white powdery subs			1	a month.		:
	: ! 15 Room 702 The	e frame of one bed was soiled			Housekeeping		
	: with heavy dust.	and of the ped was stilled			Supervisor/Designee will		:
	· will floavy dubt.			•	complete an audit for dust to	bed	;
	: 16. Room 910-The	frames of both beds were		:	frames, dining room chairs,		
	soiled with heavy d				resident room chairs and ove	rbed	•
		•			lights monthly for three mon		
		frames of one bed was soiled			then quarterly for the remain		:
	with heavy dust.	·			the year. Findings will be		!
	į			- 1	reported to the QA committee	e.	•

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ILTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		•	A. BUILT		
		155668	B. WING	3	02/07/2011
	ROVIDER OR SUPPLIER ENCE RETIREMENT I	HOME	5	STREET ADDRESS, CITY, STATE, ZIP CODE 4915 CHARLESTOWN ROAD NEW ALBANY, IN 47150	
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SS=D	18. Room 912- The soiled with heavy did 19. Room 913- The over the bed light w 20. In interview with Housekeeping on 0 indicated bed frame rooms are deep cle. She provided a cop Cleaning Rooms" at The checklist include "Bedroom" Overbe "Bed", Frame. 3.1-19(f) 483.20, 483.20(b) CASSESSMENTS	e frames of both beds were ust. e frame of one bed and one was soiled with heavy dust. In the Director of 2/03/11 at 12:45 p.m., she as are cleaned when the aned monthly. by of the "Checklist For Deep to 1:30 p.m., on this same date. led under the section for doinght and under section. COMPREHENSIVE Induct initially and periodically	F 25	action/s be monitored to ensemble deficient practice will not recur, i.e., what quality assurance program will be into place? Housekeeping Supervisor/Designee will complete and audit for dust to frames, dining room chairs, resident room chairs and over lights monthly for three month then quarterly for the remaind the year. Findings will be reported to the QA committee.	ot put bed ths, der of
	reproducible assess functional capacity. A facility must make assessment of a respecified by the Stainclude at least the Identification and de Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior Psychosocial well-b	sident's needs, using the RAI ite. The assessment must following: emographic information; patterns;		1)What corrective action/s be accomplished for those residents found to have bee affected by the deficient practice? Upon readmission to the faci Resident #78 will be assessed after each return from dialysit treatment to check shunt site condition along with vital sig and check fro thrill/bruit of siles.	lity d is and

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILD	ING		
		155668	B. WING		02/07/2011	
NAME OF P	ROVIDER OR SUPPLIER		s.	TREET ADDRESS, CITY, STATE, ZIP CODE 4915 CHARLESTOWN ROAD		
PROVIDI	ENCE RETIREMENT I	HOME		NEW ALBANY, IN 47150		
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F 272	Disease diagnosis Dental and nutrition Skin conditions; Activity pursuit; Medications; Special treatments Discharge potentia Documentation of sithe additional asseresident assessme Documentation of procumentation of procumentati	and health conditions; nal status; and procedures; i; summary information regarding ssment performed through the	F 27	the potential to be affected the same deficient practice be identified and what corrective action/s will be to One other resident is received dialysis at this time and will assessments completed after return from dialysis treatment stated. 3) What measure will be put	by will taken. ng have each at as	
	by: Based on record refailed to assess a ridialysis treatment to blood was flowing to shunt site condition affected 1 of 1 dialydialysis care in a set (Resident #78) Finding includes: Review of the clinic	eview and interview, the facility esident after each return from o check for thrill/bruit [how well through shunt], vital signs, and a. This deficient practice ysis resident reviewed for ample of 24 residents.		place or what systemic char will be made to ensure that deficient practice does not recur? Licensed staff will be in-serv on assessment of a resident ureturn from dialysis which wi include documenting the thrill/bruit, vital signs and shu site condition.	the iced pon Il	
	2/2/2011 at 11:50 a re-admitted to the 1 had diagnoses while limited to, end stage insufficiency, and compared to the end of the end	a.m., indicated the resident was in acility from the hospital and inch included, but were not e renal disease, chronic rehalt chronic ischemic heart disease.		Director of Nursing/Designee complete a weekly audit for o month, monthly for three mon and then quarterly for the remainder of the year for assessment documentation afteresidents return from dialysis. Findings will be reported to the QA committee.	ne nths eer	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	site (i.e. bandage de vital signs, and wheel present. During an interview [Minimum Data Set 2/2/2011 at 12:32 personal should be documed each time the reside what the site looked signs including a resident personal per	g the appearance of her shunt by or any signs of bleeding), either a thrill and bruit were with LPN #3 and the MDS is assessment coordinator on o.m., they indicated there intation in the nursing notes lent returned from dialysis on d and sounded like and vital eiturn weight. What with the Director of Nursing at 2:33 p.m., she indicated she by and procedure for care of a cut her expectations were for ning vital signs, mental status, and site each time the resident	F 2	72	4)How will the corrective action/s be monitored to ethe deficient practice will recur, i.e., what quality assurance program will be into place? Director of Nursing/Design complete a weekly audit for month, monthly for three mand then quarterly for the remainder of the year for assessment documentation a resident return from dialysis Findings will be reported to QA committee.	e put ee will one onths	3/9/11
F 279 SS=D	to develop, review comprehensive plate The facility must desplan for each reside objectives and time medical, nursing, a needs that are idea assessment. The care plan must to be furnished to a	E CARE PLANS the results of the assessment and revise the resident's	F2	279	1)What corrective action/s be accomplished for those residents found to have be affected by the deficient practice? A care plan will be implemented for Resident#78 to address the resident's dialysis needs, should sign, thrill/bruit of shunt prior to after returning each time from hemodialysis center.	en ented he unt	

NAME OF PROVIDER OR SUPPLIER PROVIDENCE RETIREMENT HOME STREET ADDRESS, CITY, STATE, ZIP CODE 4915 CHARLESTOWN ROAD NEW ALBANY, IN 47150 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 4915 CHARLESTOWN ROAD NEW ALBANY, IN 47150 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLETED TO THE APPROPRIATE DATE) COMPLETED TO THE APPROPRIATE DATE		STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER PROVIDENCE RETIREMENT HOME 4915 CHARLESTOWN ROAD NEW ALBANY, IN 47150 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) STREET ADDRESS, CITY, STATE, ZIP CODE 4915 CHARLESTOWN ROAD NEW ALBANY, IN 47150 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETIC GRACH CORRECTIVE ACTION SHOULD BE COMPLETIC DATE			155668	B. WING_		02/07/2011	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETIC TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE			HOME	4	4915 CHARLESTOWN ROAD		
· · · · · · · · · · · · · · · · ·	PREFIX	(EACH DEFICIENC)	' MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE COMPLETION	
F 279 Continued From page 6 psychosocial well-being as required under §483.25, and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10 (b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to develop a care plan which addressed the needs of a dialysis resident, shunt site and care, vital signs, thrill/bruit of shunt how well blood was flowing through shunt) of a resident prior to and after returning each time from the hemodialysis center. This deficient practice affected to of 1 resident receiving hemodialysis in a sample of 24 residents. (Resident #78) Finding includes: Review of the clinical record for Resident #78 on 2/2/2011 at 11:50 a.m., indicated the resident was re-admitted to the facility from the hospital and had diagnoses which included, but were not limited to, end stage renal disease, chronic renal insufficiency, and chronic ischemic heart disease. Among the admission orders was an order for hemodialysis three times a week. Nursing notes between 1/19/2011 and 1/31/2011 failed to locate documentation of an assessment of the resident after she returned from dialysis each time, including the appearance of her shunt site (i.e. bandage dry or any signs of bleeding), vital signs, and whether a thrill and bruit were present.		psychosocial well-b §483.25; and any s be required under § due to the resident §483.10, including under §483.10 (b) (4 This REQUIREMEI by: Based on record refailed to develop a needs of a dialysis vital signs, thrill/bru flowing through shu after returning each center. This deficie resident receiving hresidents. (Resider Finding includes: Review of the clinic 2/2/2011 at 11:50 a re-admitted to the final had diagnoses which limited to, end stag insufficiency, and consumption of the resident after each time, including site (i.e. bandage divital signs, and when when the signs, and when the side of the resident after each time, including site (i.e. bandage divital signs, and when the side of the resident after each time, including site (i.e. bandage divital signs, and when the side of the resident after each time, including site (i.e. bandage divital signs, and when the side of the resident after each time, including site (i.e. bandage divital signs, and when the side of the resident after each time, including site (i.e. bandage divital signs, and when the side of the resident after each time, including site (i.e. bandage divital signs, and when the side of the resident after each time, including site (i.e. bandage divital signs, and when the side of the resident after each time, including site (i.e. bandage divital signs, and when the side of the resident after each time.	eing as required under ervices that would otherwise (483.25 but are not provided is exercise of rights under the right to refuse treatment). In it is not met as evidenced view and interview, the facility care plan which addressed the resident, shunt site and care, it of shunt [how well blood was unt] of a resident prior to and a time from the hemodialysis interactice affected 1 of 1 the production of a sample of 24 at #78) In all record for Resident #78 on the included, but were not be renal disease, chronic renal thronic ischemic heart disease. In on orders was an order for times a week. In the included is a sample of 24 at #78 and the included is a sample of 24 at #78.	F 279	2)How other residents have the potential to be affected the same deficient practice be identified and what corrective action/s will be to the other resident is received dialysis at this time and has a potential to be affected by the practice. A care plan will be implemented upon admission the facility for this resident. 3)What measure will be purplace or what systemic charwill be made to ensure that deficient practice does not recur? Licensed staff will be in-served on the need to care plan the reforming and thrill/bruit of resident prior to and after returning each time from the hemodialysis center. Director of Nursing/Designer audit monthly for three montand then quarterly for the remainder of the year to ensure development of a care plan of those residents receiving dial Findings will be reported to the server of the president of the pres	by will aken. ng the is is in to at into nges the viced needs lysis is a e will hs re f ysis.	

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	ROVIDER OR SUPPLIER	HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 4915 CHARLESTOWN ROAD NEW ALBANY, IN 47150			
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F 279 F 322 SS=D	Review of the care to locate a care pla needs of a dialysis and care (i.e. no ne in arm with shunt, a at site), thrill and br During an interview Set] assessment con 12:32 p.m., she indepreliminary care pla and she would do to the she also indicated meeting, she would additional information of the should have be also indicated meeting, she would additional information of the should have be also indicated meeting, she would additional information of the should have be also indicated meeting, she would additional information of the should have be also indicated meeting, she would additional information of the should have be also indicated meeting, she would additional information of the should have be also indicated meeting and the care for the should have be also indicated meeting and should have be also indicated meet	plans for Resident #78 failed in which addressed the special resident, including shunt site redie sticks or blood pressure absence or presence of blood wit of shunt, and vital signs. With MDS [Minimum Data coordinator on 2/2/2011 at icated nursing would do a rean on dialysis and shunt care the admission assessments. It is that by the first care plan with any on. With the Director of Nursing resident at 12:32 p.m., she indicated been a care plan to address dialysis resident. REATMENT/SERVICES - SKILLS The system of a resident resident are sident are sident are sident are sident are sident and services on pneumonia, diarrhea, on, metabolic abnormalities, and ulcers and to restore, if		322	4) How will the corrective action/s be monitored to enter the deficient practice will marecur, i.e. what quality assurance program will be into place? Director of Nursing/Designer audit monthly for three montand then quarterly for the remainder of the year to ensut the development of a care plathose residents receiving dial Findings will be reported to to QA committee. 1) What corrective action/s be accomplished for those residents found to have been affected by the deficient practice? Resident #69 is receiving all medications administered that the G-tube per facility policy	put e will hs re n of ysis. he will en	3/9/11

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	ROVIDER OR SUPPLIER	НОМЕ		49	EET ADDRESS, CITY, STATE, ZIP CODE 15 CHARLESTOWN ROAD EW ALBANY, IN 47150		
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	review, the facility figiven through a gas administered accor resident observed rube during the medicate tube during the medicate. During the medicate 8:25 a.m. and 9 a.n. LPN #4 was observed medications to Resident of the medication of the medicate of the me	on, interview and record alled to ensure medications strostomy tube were ding to facility policy for 1 of 1 receiving medications via G dication pass. (Resident #69) ion pass on 2/2/11 between n., the following was observed: red giving the following ident #69. Hydrocodone (pain milligram) PGT (per q. (every) 2 hours; Calcium IU (strengthen bone) give 1 imes a day; Magnesium reristalsis and bowel q tablet. Give 2 tablets (800 r. Metoprolol tartrate (to treat a) 25 mg tablet give 1 tablet via y." All of the medications are Physician's Order dated dual, and began by giving the meters) Normal Saline flush are flush and poured all of the into the syringe adding more of medications had not been orior to administration. She in to push the medications and flushed with normal	F3	322	2)How other residents have the potential to be affected the same deficient practice be identified and what corrective action/s will be. Two other residents in the f have the potential to be affected by this practice. The Direct Nursing/Designee will commedication pass audit on the residents receiving medicate through a G-tube to ensure medications are being administered according to f policy. 3)What measures will be into place or what systemic changes will be made to enthat the deficient practice not recur? Licensed staff/Qualified Medication Techs will be in serviced on facility policy of giving medications through gastrostomy tube. Policy on administration of medications through a gastrostomy tube has been reviewed and revised.	by will taken. acility acted or of plete ese ions the acility put ic nsure does	
		(sic) Nutrition, dated 10/8/10, ector of Nursing on 2/2/11 at		***************************************		,	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	JLTIPI	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
MITO I DATE	o difficulties	DERTH OF HOMBER	A. BUI	DING		COMPLE	.120
		155668	B. WIN	G		02/0	7/2011
NAME OF P	ROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE		
PROVIDA	ENCE RETIREMENT I	HOME		NEW ALBANY, IN 47150			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORREC PREFIX (EACH CORRECTIVE ACTION SHO TAG CROSS-REFERENCED TO THE APPR DEFICIENCY)		ULD BE	(X5) COMPLETION DATE
F 323 SS=D	"Medications 1. C. administered, crust and mix in tap water On 2/2/11 at 3:30 p Director of Nursing medications through would have to review 3.1-44(a)(2) 483.25(h) FREE OFFI HAZARDS/SUPER The facility must errenvironment remains is possible; and adequate supervisity prevent accidents. This REQUIREMED by: Based on record refailed to provide adcognitively impaired was at risk for falls.	, but was not limited to If crushed tablets are in the tablet to a fine powder ir" I.m., in interview with the i, when queried about giving in a g-tube, she indicated she is with policy. FACCIDENT VISION/DEVICES Issure that the resident ins as free of accident hazards each resident receives on and assistance devices to NT is not met as evidenced Iview and interview, the facility equate supervision for a direction resident (Resident #73) who and had two falls within 2 tes, for 1 of 7 residents	F3	322	Director of Nursing/Designed complete medication administration audits on G-toresidents monthly for three months and then quarterly for remainder of the year. Finding will be reported to the QA committee. 4) How will the corrective action/s be monitored to ensithe deficient practice will not recur, i.e. what quality assurance program will be printo place? Director of Nursing/Designed complete medication administration audits on G-turn residents monthly for three months and then quarterly for remainder of they year. Finding will be reported to the QA committee.	the ngs ure t will be	3/9/11
	The clinical record on 2/2/11 at 11:40	for Resident #73 was reviewed a.m. The resident diagnoses not limited to, hypertension, e, and dementia.	F3:	23	1)What corrective action/s we be accomplished for those residents found to have been affected by the deficient practice?		

STATEMENT	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) N	ALILTI!	PLE CONSTRUCTION	(X3) DATE S	. 0830-0381
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI			COMPLE	
		155668	B. WII	√G		. 02/0	7/2011
NAMEOFP	PROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE		
PROVIDI	ENCE RETIREMENT	HOME			915 CHARLESTOWN ROAD		
	1 CHAMADY OT		·	N	IEW ALBANY, IN 47150		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 323	Continued From pa	age 10	F:	323	Unable to correct for Reside	ent #73	
		uded, but were not limited to:		1	but the care plan for falls of		
		Rm (room) mate came out in			Resident#73 will be review		ļ
		staff of Res. (resident) on floor.		:	updated as needed.		
		tocks propped up with hands		:			!
ł		stated 'I was trying to shut the in-skid socks on - stated 'I just		,	2)How other residents have	'ing	
	slid down."	Parid abolta off Stated That		1	the potential to be affected		
		!			the same deficient practic	e will	
		V/S (vital signs) 169/82, 97.9,	 	i	be identified and what		
	room per CNA (cer	aturation) Nurse called to res. I		ļ	corrective action/s will be	taken.	
		m and heard a loud noise,	į	l	Director of Nursing/Design	ee will	ļ
		n res. was noted sitting on the			complete a falls assessment		· ·
		back against the wall (where			review of care plan on all		
1		between side A + B of the 'No body answered the phone,			residents who have been id-	entified	1.
		wer the phone it might be		ļ	to be a risk for falls for		. %
	[named].' Res. ver	ry confused doesn't know		1	appropriate interventions.		
		s she's in her mother's room. ate. Supervisor notified. Res		ļ	3)What measure will be pu	e into	
		entimeter) x 0.2 cm S/T		. !	place or what systemic cha		1
		t) elbow. No other injuries		ļ	will be made to ensure that		"
ļ	noted. Res. assiste	ed to bathroom + back to bed		i	deficient practice does not	, there	
		Call light with in reach. Will			recur?		
	cont. (continue) to	monitor."					ļ
	The risk for falls ca	are plan dated 6/2/2010			All Licensed staff will be in-	P	1
		not limited to "Focus: Risk for		f	serviced on assessing resider	ats for	
		s, decreased endurance,	! :		risk for falls, putting new		
	impaired judgemen	nt, cognitive impairment:	!		interventions into place after	each	
·		ist with toileting as needed.,			fall and updating care plans		
		l & bed in lowest position.,			accordingly.		!
		is needed., Keep call light & ms within reach when in room.,	ſ				•
		ins within reach when in room., · is in safety & intervene as	•				,
		or for S/S (signs/symptoms) of					•
		lications., Non skid footwear.,	į	i	i		
	Pathways well lit &	clutter free.,			ţ i		
	Restorative/Therar	by as indicated., Encouraged		i	i [

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
		l l l l l l l l l l l l l l l l l l l	A. BUI	LDIN	G	COMPLE	-150	
		155668	B. WII	۱G		02/0	7/2011	
NAME OF P	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE			
PROVIDE	NCE RETIREMENT I	HOME			915 CHARLESTOWN ROAD IEW ALBANY, IN 47150			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	1D		PROVIDER'S PLAN OF CORREC	TION		
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	: (X5) - COMPLETION - DATE	
F 323	Continued From pa	nge 11	F:	323	Director of Nursing/Design		•	
		light & let staff help her (no			complete an audit monthly		:	
	date as to when ad			ļ	three months and then quart			
,	A - A - - 11 / 4				for the remainder of the year		;	
	2011 included, but	Care Plan dated January 4,			ensure that residents who have			
		k of Falls R/T History of Falls			been identified as being a ri falls have been assessed,	SK 101	;	
		2; Plan of Approach: Keep call:			interventions put into place	and		
	light and frequently	used items in place, non-skid		į	care plan updated. Finding		:	
		ith toileting; Assess for			be reported to the QA com			
		ards (clutter) Therapy or cated; Assistive device with in			•			
		es 1/4/11; 1/4/11 Enc			4)How will the corrective		!	
		nt to use call light for assist;			action/s be monitored to e		,	
		Urinalysis); 1/5/11 Sensor pad			the deficient practice will	not		
	to bed & chair at all	I times"			recur, i.e., what quality			
	The most recent O	uarterly Minimum Data Set			assurance program will be	put		
	dated 12/09/10 lack	ked a code for the section			into place?			
	"Cognitive Skills for	r Daily Decision Making."			Director of Nursing/Design	ee will	:	
	During the initial to	: ur with LPN (Licensed Practical)			complete an audit month fo		:	
		ary 31, 2011 between 1:20			months and then quarterly:	or the	:	
	p.m. and 2:30 p.m.	, she identified the resident as			remainder of the year to en			
	"confused."				that residents who have bee			
					identified as being a risk fo			
		e Director of Nursing on 2/7/11			have been assessed, interve			
	the call light, doesn	dicated "the resident can use			put into place and care plar	į.		
;	ino odningna, docom	1 2 400 10.			updated. Findings will be	t	3/9/11	
	3.1-45(a)(2)				reported to the QA commit	iee,		
F9999	FINAL OBSERVAT	TONS	F9:	999	: •			
	State Findings			;	•			
	3.1-14 PERSONNE	EL						
	employee of a facili	ation shall be required for each ity within one (1) month prior to examination shall include a			,			

					-		-	
DEPAR	TMENT OF HEALTH	HAND HUMAN SERVICES				PRINTER	D: 02/11/201	
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				FORM	M APPROVED	
STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	ULTIF	PLE CONSTRUCTION	1	D. 0938-039 ⁻	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		A. BUILDING			(X3) DATE SURVEY COMPLETED	
		155668	B. WIN	G_		02/	07/0044	
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS CITY STATE TO SE			02/07/2011		
PROVIDENCE RETIREMENT HOME				49	EET ADDRESS, CITY, STATE, ZIP CODE 215 CHARLESTOWN ROAD			
FRUVID	ENCE KETIKEMENT	TOME		NEW ALBANY, IN 47150				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	_ .				
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			x	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU	TION TION	(X5) COMPLETION	
TAG				Ì	CROSS-REFERENCED TO THE APPRI	OPRIATE	DATE	
	1				DEFICIENCY)		ļ	
F9999	Continued From page	ge 12	F999	99	1)What corrective action/s	will		
	tuberculin skin test	, using the Mantoux method (5	•		be accomplished for those	AA ETE		
	↓TU PPD), administe	ered by persons having			residents found to have been		İ	
	documentation of training from a department-				affected by the deficient			
	approved course of instruction in intradermal				practice?			
	tuberculin skin testing, reading, and recording			į	hracuce:		ļ	
	unless a previously	positive reaction can be			No recident was form 1 to 1			
	documented. The re	esult shall be recorded in			No resident was found to be			
İ	millimeters of induration with the date given, date			İ	affected. LPN#2 is no longer	r		
į	read, and by whom administered. The tuberculin				employed at the facility.			
	skin test must be read prior to the employee				2)77			
	starting work. The facility must assure the				2)How other residents having	ng	1	
	following: At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid				the potential to be affected l	by		
					the same deficient practice will		1 -	
į	personnel of facilitie	e chall be eccepted for			be identified and what		1	
	personnel of facilities shall be screened for tuberculosis. For health care workers who have			l	corrective action/s will be ta	ken.	1.	
į	not had a documented negative tuberculin skin						! :.	
	test result during the preceding twelve (12)				Director of Nursing/Designee	will		
į	months, the baseline tuberculin skin testing				complete audit of employees t	to ·		
!	should employ the two-step method. If the first				identify if there are any other			
!	step is negative, a second test should be				employees who were not scree	ened		
	performed one (1) to three (3) weeks after the			j	for TB at time of employment	. Vi.	Ţ	
!	first step. The frequency of repeat testing will			İ	within one month prior to	. 01].	
! !	depend on the risk o	of infection with tuberculosis.			employment for the past year.	TD	1 .	
	;	•		ļ	testing will be completed on a	1 <i>D</i>		
j	This State Rule was	not met as evidenced by:			employee that may be identified	лу 1		
ĺ				ļ	omprojee mat may be memming	ea.	j I	
į	Based on record rev	iew and interview, the facility		1	2)What magazine will be		ļ	
į	ralled to ensure emp	ployees were screened for			3)What measure will be put i	into		
1	tuberculosis at the time of employment or within			!	place or what systemic chang	ses		
!	one month prior to employment. This deficient			į	will be made to ensure that the	he j	! !	
:	practice affected 1 of 5 employee whose files			į	deficient practice does not	;		
	were reviewed. (LPN #2)			Ċ	recur?		. }	

FORM CMS-2567(02-99) Previous Versions Obsolete

Findings include:

following was identified:

During the review of the employee files on 02/03/11 between 10:30 a.m., and 11:45 a.m., the

Event ID: TO8K11

Facility ID: 001144

recur?

The Staff Development

starting employment.

Coordinator will be in-serviced on

completing TB on all potential employees within 30 days of

If continuation sheet Page 13 of 14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	- 1	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
	155668	B. WI	B. WING		02/0	02/07/2011	
NAME OF PROVIDER OR SUPPLIER PROVIDENCE RETIREMENT HOME			49	REET ADDRESS, CITY, STATE, ZIP CODE 915 CHARLESTOWN ROAD IEW ALBANY, IN 47150		,2011	
PREFIX (EACH DEFICIENCY	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		IX S	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
10/26/10, lacked do tuberculosis at the tuberculin skin test the place of previou In interview with Lic 12:30 p.m., on 02/0	Nurse #2, with hire date of ocumentation of screening for time of employment. The last was administered 12/27/09, at	F9	999	Staff Development Coordinator/Designee will complete a monthly audit f months and then quarterly remainder of the year on ne hires to verify TB testing is completed at time of emple or within one month prior t employment. Findings wil reported to the QA commit 4) How will the corrective action/s be monitored to a the deficient practice will recur, i.e., what quality assurance program will b into place? Staff Development Coordinator/Designee will complete a monthly audit fo months and then quarterly for remainder of the year on ne hires to verify TB testing is completed at time of emplo or within one month prior to employment. Findings will reported to the QA committe	for the ew s syment o l be tee. ensure not e put or three for the w yment o be	3/9/11	

Indiana State Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 155668 02/07/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4915 CHARLESTOWN ROAD PROVIDENCE RETIREMENT HOME NEW ALBANY, IN 47150 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) R 000 INITIAL COMMENTS R 000 The following state residential deficiency is cited in accordance with 410 IAC 16.2-5. 1) What corrective action/s will be accomplished for those R 217 410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency R 217 residents found to have been (e) Following completion of an evaluation, the affected by the deficient facility, using appropriately trained staff members, practice? shall identify and document the services to be provided by the facility, as follows: Residential Residents # 4 will (1) The services offered to the individual resident have a written service plan shall be appropriate to the: implemented and will have their (A) scope; service plan reviewed with the (B) frequency; resident and signed by the (C) need; and resident. (D) preference: of the resident. (2) The services offered shall be reviewed and Unable to correct for Residential revised as appropriate and discussed by the Resident #5 due to this individual resident and facility as needs or desires change. has been discharged to home. Either the facility or the resident may request a service plan review. 2) How other residents having (3) The agreed upon service plan shall be signed the potential to be affected by and dated by the resident, and a copy of the the same deficient practice will service plan shall be given to the resident upon be identified and what request. corrective action/s will be taken. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no All residential residents will be need for a change in services. reviewed to verify there is a (5) If administration of medications or the service plan in place and has been provision of residential nursing services, or both, reviewed with the resident and is needed, a licensed nurse shall be involved in signed by the resident. identification and documentation of the services to be provided. 3) What measure will be put into place or what systemic changes This RULE is not met as evidenced by: will be made to ensure that the Based on record review and interview, the facility deficient practice does not failed to develop a service plan which identified and documented the services the facility would Indiana State Department of Health

STATE FORM

689

LABORATORY DIRECTOR'S OR PROVIDERISHPPHER REPRESENTATIVE'S SIGNATURE

TO8K11

(X6) DATE

If continuation sheet 1 of 3

Indiana State Department of Health STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING B. WING 155668 02/07/2011 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 4915 CHARLESTOWN ROAD PROVIDENCE RETIREMENT HOME NEW ALBANY, IN 47150 (X4) ID i SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) R 217 R 217: Continued From page 1 The residential policy on Resident Plan of Care/Service Plan will be provide for 2 of 3 residents reviewed for service plans in a sample of 5 residential residents reviewed and updated and (Residential Residents #4 and #5) and failed to Licensed staff and Social Services review and discuss the service plans with and staff will be in-serviced on policy : have it signed by 1 of 3 residents reviewed for which will include completing asigned service plans in a sample of 5 residential service plan at time of admission, residents (Residential Resident #4). reviewing with resident, and having resident sign the plan. Findings included: 1. Review of the clinical record for Residential Director of Nursing/Designee will Resident #4 on 2/3/2011 at 11:50 a.m., indicated complete an audit monthly and the resident had diagnoses which included, but then quarterly for the remainder of were not limited to, hypertension, dizziness, the year to verify service plans are gastroesophageal reflux disease, major in place, reviewed with resident depressive disorder, and coronary and resident has signed the service atherosclerosis. plan. Findings will be reported to the QA committee. On 2/7/2011 at 7:55 a.m., the Director of Nursing [DoN] presented a copy of Residential Resident 4) How will the corrective #4's current service plans in place with review action/s will be monitored to dates of every 6 months, but documentation was ensure the deficient practice will i lacking as to who would be responsible for not recur, i.e. what quality providing those services to the resident. assurance program will be put Documentation was also lacking to indicate the into place? service plans had been discussed with and signed by the resident. Director of Nursing/Designee will complete an audit monthly and 2. Review of the clinical record for Residential Resident #5 on 2/3/2011 at 9:15 a.m., indicated then quarterly for the remainder of the resident was admitted on 9/6/2010 and had the year to verify service plans are diagnoses which included, but were not limited to, in place, reviewed with resident dementia, hypertension, type 2 diabetes mellitus, and resident has signed the service peripheral neuropathy. plan. Findings will be reported to the OA committee. Documentation was lacking of a service plan having been developed to indicate what type of assistance the resident required and who would be providing those services.

Indiana State Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 155668 02/07/2011 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 4915 CHARLESTOWN ROAD PROVIDENCE RETIREMENT HOME NEW ALBANY, IN 47150 PROVIDER'S PLAN OF CORRECTION (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) R 217 Continued From page 2 R 217 During an interview with the DoN on 2/7/2011 at 8:37 a.m., she indicated that she was unable to locate any service plans for Resident #5. On 2/7/2011 at 7:55 a.m., the DoN also presented a copy of the facility's current residential policy on "Resident Plan of Care/Service Plan". Review of this policy at this time included, but was not limited to, "Policy: It is the policy of [facility] to identify the care needs of the Residential Care resident and to develop a Plan of Care/Service Plan. Procedure: 1. Upon admission, the resident will have a nursing assessment completed. 2. A Plan of Care/Service Plan will be developed based on this assessment to include all needs identified..." 3/9/11

Indiana State Department of Health